Guidelines for Neuraxial Anesthesia in Obstetrics

Committee of Origin: Obstetric Anesthesia

(Approved by the ASA House of Delegates on October 12, 1988, and last amended on October 17, 2018)

These guidelines apply to the use of neuraxial anesthesia administered to the parturient during labor and delivery and are intended to encourage quality patient care but cannot guarantee any specific patient outcome. Because the availability of anesthesia resources may vary, members are responsible for interpreting and establishing the guidelines for their own institutions and practices. These guidelines are subject to revision from time to time as warranted by the evolution of technology and practice.

GUIDELINE I
Neuraxial anesthesia should be initiated and maintained only in locations in which appropriate resuscitation equipment and drugs are immediately available to manage procedurally related problems.

Resuscitation equipment should include, but is not limited to: sources of oxygen and suction, equipment to maintain an airway and perform endotracheal intubation, a means to provide positive pressure ventilation, and drugs and equipment for cardiopulmonary resuscitation.

GUIDELINE II
Neuraxial anesthesia should be initiated and maintained by a physician with appropriate privileges or under the medical direction [1] of such an individual.

Physicians should be approved through the institutional credentialing process to initiate and direct the maintenance of obstetric anesthesia and to manage procedurally related complications.

GUIDELINE III
Neuraxial anesthesia should not be administered until: 1) the patient has been examined by a qualified individual[2]; and 2) a physician with obstetrical privileges to perform operative vaginal or cesarean delivery, who has knowledge of the maternal and fetal status and the progress of labor and who agrees with the initiation of labor anesthesia, is readily available to supervise the labor and manage any obstetric complications that may arise.

Under circumstances defined by department protocol, qualified personnel may perform the initial pelvic examination. The physician responsible for the patient's obstetrical care should be informed of her status so that a decision can be made regarding present risk and further management. [2]

GUIDELINE IV

An intravenous infusion should be established before the initiation of neuraxial anesthesia and maintained throughout the duration of the neuraxial anesthetic.

GUIDELINE V
Neuraxial anesthesia for labor and/or vaginal delivery requires that the parturient's vital signs and the fetal heart rate be monitored and documented by a qualified individual. Monitoring technique, frequency of recording and additional monitoring should be chosen with regard to the clinical condition of the parturient and fetus and in accordance with institutional policy. When extensive neuraxial blockade is administered for complicated vaginal delivery, the standards for basic anesthetic monitoring[3] should be applied.

GUIDELINE VI
Neuraxial anesthesia for cesarean delivery requires that the standards for basic anesthetic monitoring[3] be applied and that a physician with privileges in obstetrics be immediately available.

GUIDELINE VII
Qualified personnel, other than the anesthesiologist attending the mother, should be immediately available to assume responsibility for resuscitation of the newborn.[3]

The primary responsibility of the anesthesiologist is to provide care to the mother. If the anesthesiologist is also requested to provide brief assistance in the care of the newborn, the benefit to the child must be compared to the risk to the mother.

GUIDELINE VIII
A physician with appropriate privileges should remain readily available during the neuraxial anesthetic to manage anesthetic complications until the patient's postanesthesia condition is satisfactory and stable.

GUIDELINE IX
All patients recovering from neuraxial anesthesia should receive appropriate postanesthesia care. Following cesarean delivery and/or extensive neuraxial blockade, the standards for post-anesthesia care [4] should be applied.

GUIDELINE X
There should be a policy to assure the availability in the facility of a physician to manage complications and to provide cardiopulmonary resuscitation for patients receiving postanesthesia care.

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1. Statement on the Anesthesia Care Team (Approved by ASA House of Delegates 10/18/2006 and last amended 10/16/2013).

2. American Academy of Pediatrics and American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care, 8th Edition. Elk Grove Village, IL: AAP; Washington, DC: ACOG, 2017.

3. Standards for Basic Anesthetic Monitoring (Approved by ASA House of Delegates 10/21/86 and last amended 10/28/2015).

4. Standards for Postanesthesia Care (Approved by ASA House of Delegates 10/27/2004 and last amended 10/15/2014).